STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 00 B. WING	03/07/2012

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F0000	This visit was for Investigation of Complaints IN00103352, IN00104411, and IN00104548. Complaint IN00103352 - Substantiated. Federal/State deficiencies related to the allegations are cited at F159 and F514. Complaint IN00104411 - Substantiated. Federal/State deficiencies related to the allegations are cited at F253 and F465. Complaint IN00104548 - Substantiated. Federal/State deficiencies related to the allegation is cited at F441. Unrelated deficiencies cited. Survey dates: March 6 & 7, 2012 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Survey team: Mary Jane G. Fischer, RN Census bed type: SNF: 17 SNF/NF: 103 Total: 120	F0000	The creation and submission of this Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or after April 6, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census payor type: Medicare: 26 Medicaid: 79 Other: 15 Total: 120 Sample: 5 Supplemental sample: 2 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on March 9, 2012 by Bev Faulkner, RN			

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F0159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount			

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	in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on record review and interview, the facility failed to safeguard and account for personal funds, in that when the facility obtained the services of a local shopping service, the facility staff accessed the resident trust fund account without prior approval to pay for items purchased by residents who either had a guardian, power of attorney or were deemed cognitively impaired to make daily decisions. This deficient practice effected 3 of 3 residents sampled with trust fund accounts in a sample of 5 and 2 of 2 supplemental sampled residents, which had the potential to effect 71 residents who the facility identified with the safeguard of resident trust fund account. [Residents "A", "B", "D", "F", and "G"]. Findings include: 1. During interview on 03-06-12 at 8:55 a.m., a concerned family member for Resident "A" indicated the facility took [resident] to the shopping service in September 2011, and allowed the resident	F0159	It is the practice of this facility to provide Management of Personal Funds for residents.**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · This resident family member had voiced this issue to the Executive Director. Upon verification of the transaction, the Executive Director ordered a check to be given to the resident's daughter for the $171.13 so that the family could shop for the resident and replace items that were described as not found. · Administrator made calls to the other 4 residents identified to discuss the shopping experience and offer resolutions to areas of concern with the POA's. **2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected. · Onsite shopping experiences will be discontinued. · The Facility does provide shopping trips to Walmart.**3. What measures will**	04/06/2012

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	to purchase items in the amount of $171.13. The family member further indicated [resident] has dementia, and "I have power of attorney, and they should have asked me first before they did that and took money from the account [resident trust]. I receive [resident's name] check and I pay the bills, but I didn't know anything about it [in reference to the shopping] until I got the quarterly statement. When I checked [resident's name] closet there were no new clothing items there. I went to [name of Assistant Business Office Manager, employee #9] who told me the whole thing was a mistake. They even had [resident] sign a paper for the things that were purchased. [Resident] doesn't know what [resident] is signing. I talked to the Administrator and they are going to refund the money." Review of Resident "A" clinical record on 03-06-12 at 11:15 a.m., indicated the resident had a diagnosis which included dementia with delusions. The record also contained the documentation which identified the family member as the Power of Attorney, dated 02-26-82, for the resident. A review of the "Merchandise Invoice," dated September 6, 2011, for the amount of $171.13 for "jewelry item [$5.99],		**be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Onsite shopping experiences will be discontinued. · The Facility does provide shopping trips to Walmart.· Social Services will contact family of residents when new clothing items are needed. · Administrator will meet with resident counsel to discuss the discontinuance of onsite shopping event. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Onsite shopping experiences will be discontinued. · The Facility does provide shopping trips to Walmart.**5. The facility alleges date of compliance on April 6, 2012**	

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	ladies 6 pk. [pack] socks [$8.99], 2 pc. [piece] decorative trim capri [$31.99], 2 pc Print knit [$32.99], 2 pc. print sweat [$29.99], Supportive undergarment [$19.99]." This invoice was signed by the Activity Director as well as the resident. The facility was unable to provide documentation of approval from the person identified as the power of attorney for the resident, for access to the trust fund account. 2. The record for Resident "B" was reviewed on 03-07-12 at 10:35 a.m. The record indicated the resident had a diagnosis of dementia and was severely cognitively impaired with both short term and long term memory loss. Further review indicated the resident had a Guardian [family member]. In addition, a handwritten Social Service Progress note dated 09-07-11 at 1:05 p.m. indicated "I, [name of guardian], will purchase all of [name of resident] clothings [sic]." This handwritten note was signed by the resident's guardian. Review of the resident's trust account ledger, dated 10-24-11, indicated "clothing $53.56." During interview on 03-07-12 at 8:25			

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	a.m., the Activity Director indicated the activity staff notified the guardian about the purchase of the clothing after it was purchased by the resident. "[Guardian] said it was ok this time but not in the future, and that [guardian] would get all items for [name of resident]." The resident record lacked documentation of the items that were purchased. The facility was unable to provide documentation of approval from the person identified as the power of attorney for the resident, to access the trust fund account or the approval for the purchase of the items. 3. The record for Resident "D" was reviewed on 03-07-12 at 10:00 a.m. A diagnoses for the resident included persistent mental disorder. The resident was identified with severe cognitive impairment and resided on the secured dementia unit. Included in the resident record was information which identified a concerned family member as the "healthcare and financial" power of attorney. The facility provided a copy of items purchased on September 6, 2011 from the shopping service. The Invoice indicated			

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	the resident purchased an embroidered knit sweater [$26.99], a 2 pc. print sweat. [$29.99], 2 pc. decorative trim capri [$28.99] and 2 pc print knit [$29.99] for a total of $155.10. This invoice was signed by the Activity Director. The facility was unable to provide documentation the resident's power of attorney approved the facility staff to access the trust account or approval for the purchase the above items. In addition, the resident Inventory sheet lacked an accounting of the items purchased. 4. The record for Resident "F" was reviewed on 03-07-12 at 10:25 a.m. The record indicated the resident had a diagnoses of dementia with agitation and depressive disorder. The record indicated the resident had an identified person as "general durable power of attorney." The record indicated the resident had "severe cognitive impairment." On 03-07-12 at 10:00 a.m., the Activity Director provided documentation/invoice, dated 09-06-11, in which the resident purchased items from the shopping service. This invoice was signed by the Activity Director. The items included			

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	ladies 6 pk socks [$8.99], ballerina slippers [$9.99], snuggies [$6.99], embroidered knit sweater [$26.99], 2 pc multiprint [$29.99], 2 pc. print knit [$29.99], and muu muu Dress [$21.99], for a total of $183.94. A "comment" at the bottom of the Invoice indicated "took all." Review of the resident record lacked documentation of items purchased from the shopping service. The facility was unable to provide documentation of approval from the person identified as the power of attorney for the resident, or for the staff to access the resident trust account for the purchase of the items. 5. The record for Resident "G" was reviewed on 03-07-12 at 10:15 a.m. The record indicated the resident had a diagnoses of Alzheimer's disease and had severe cognitive impairment. In addition, the record indicated the resident had a concerned family member as the "healthcare and financial" power of attorney. On 03-07-12 at 10:15 a.m., the Activity Director provided an invoice, dated 09-06-11, for the shopping service. This			

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	invoice was signed by the Activity Director. The invoice indicated the purchase of "ladies 6 pk. socks [$8.99], 2 pc multiprint [$29.99], 2 pc. jewel two tone [$29.99]. and cotton gown [$14.99]." The total purchase was documented at $89.84. The "comment" section at the bottom of the invoice indicated "took all." Review of the Inventory sheet lacked documentation of the items purchased. The facility was unable to provide documentation of approval from the person identified as the power of attorney to access the resident trust fund account for the purchase for the items. 6. During interview on 03-07-12 at 8:25 a.m., the Activity Director indicated the "front office/desk [in reference to facility staff] gives a list of how much total money the resident has in their account. "They are suppose to call the families. Certain family members like to come in to help buy for the residents. They [the office staff] are supposed to call and request permission. There was a sheet for them [in reference to a family member/poa/guardian] to sign. If the resident can make their own decisions, the resident buys and signs. [Name of shopping company] makes a list of what they [residents] buy and that goes to the			

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	front office - they handle it. [Name of shopping company] calls and verified with the business office. We [activity staff] don't add the items to the inventory sheet. For the residents on the Alzheimer's Unit their staff would have to bring them over to the shopping and then add to the inventory sheet." Interview on 03-06-12 at 11:25 a.m., the current Business Office Manager indicated "I just started and I'm not aware of any problems with the 'shopping service' and the resident trust account. [Name of employee #9] might know something about it." Interview on 03-06-12 at 11:35 a.m., the Business Office Assistant, employee #9, indicated, "[Name of shopping company] came in and [name of Resident "A" wanted to order clothing. Once the [family member] received the quarterly statement is when there was a problem since [family member] didn't know anything about it." When further interviewed if any other resident family member was opposed to the facility handling the transaction of the purchase of clothing, the Business Office Assistant, employee #9, indicated "yes, [name of family member for Resident "B"], the family doesn't want [resident] to purchase anything, they will take care of it."			

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Interview on 03-07-12 at 9:40 a.m., Licensed Practical Nurse, employee #13, indicated "We don't add anything to the inventory sheet when they [in reference to the residents] go over there to shop. If that's something we're suppose to do, we'll do it."

7. Review of the "Facility Charge Form," for the shopping service and provided on 03-07-12 at 10:00 a.m., by the Activity Director, included the following information:

"Today's date, Facility Name, Address, City, State, Zip."
"Due to unforeseen circumstances, [name of shopping service] did not receive a check the day of the sale for merchandise charged to resident's facility accounts. Although payment is customarily due upon receipt of good, an extension has been granted to the above listed facility. Payment in full is expected within 5 business days. Thank you for your prompt attention."

* The total amount due from facility for sale is $_____ (see attached facility summary report).

* Invoices were given to _____, Title: _____.

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	* Person in charge of sending payment: _____, Title: _____. Direct Phone Line: _____. Best hours to reach: _____. * Corporate Offices: _____. * Contact: _____ Phone: _____. * Signed By: _____. * Shopping Service Representative: _____ . This Federal tag relates to complaint IN00103352. 3.1-6(b)			

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F0253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure resident areas were clean, sanitary and maintained in good repair for 3 of 3 units observed. (Moving Forward Unit, A-C Unit and Auguste's Cottage). This failure had the potential to affect all residents. Findings include: During observation on 03-06-12 at 9:10 a.m., the following environmental conditions were observed with the Maintenance Supervisor in attendance. Moving Forward Unit: The office used by the Social Service Director and frequented by residents and family members had a heavy build up of a thick, gray, fuzzy substance in the ceiling air duct. The shower room on this Unit had black objects in the diffuser of the overhead florescent lighting and the shower curtain was not affixed to the metal track in the ceiling. Therapy Gym: a 3 foot by 4 inch span in	F0253	It is the practice of the facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Air vents cleaned by Facility Maintenance Department by March 30, 2012, then vent cleaning will done on facility Preventative Maintenance Schedule and as needed. · Shower room lights diffusers cleaned by facility maintenance department. · The Therapy Gym ceiling will be painted by the maintenance department. · A-C Unit items will be bid by an outside contractor for repair. · A Hall shower room floor is to be repaired to prevent drainage into the hall. · The large scratch on the hall will be repaired by outside contractor. · Items for both the Main Dining Room and the Auguste's Cottage are being repaired in a renovation project that will be completed by April 6, 2012.	04/06/2012

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	the ceiling, adjacent to the East Exit, lacked a painted surface, and a green substance was apparent along the edges of the unpainted area. A-C Unit: A section of the ceiling which measured 4 foot by 3 foot had spackle and an unpainted surface. Shower Room: Along the edge of where the floor and wall joined was a section 4 feet in length which had a black/green substance. A sign to the door of this shower room indicated "do not use this shower room." During interview Licensed Practical Nurse, employee #5, verified, "We were told we can't use that shower room, because the water comes out into the hallway, and then settles in the hallway." Interview on 03-07-12, at 10:00 a.m., the Maintenance Supervisor indicated he came in to the facility to find a sign in the shower room, and written by the Administrator that the staff couldn't use this shower room for the residents. When they wash the wheelchairs, the water rolls out into the hallway from underneath the door and settles in front of the office of the Social Worker." A large black scratched area had been		· The cabinetry/kitchenette will be replaced as part of the Cottage renovation. · New kick plates will be added to the resident room doors on the Cottage. · Handrails will be refinished in the renovation process. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · All residents have the potential to be affected by housekeeping concerns. · Repairs and cleaning will be completed by April 6, 2012 **3. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.** · Facility has implemented a deep clean schedule to include resident's rooms and common areas. · Facility has implemented the preventative maintenance schedule to include routine cleaning of air vents, resident rooms' repairs and common areas repairs. · Staff education and return demonstration will be provided by Regional Consultant by April 6, 2012.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	gouged into the flooring on "C" hall. The scratch spanned approximately 20 feet. Main Dining Room: There were patched/spackled unpainted areas of the ceiling, which were too numerous to count. Auguste's Cottage: The cove base adjacent to the sliding patio door was not affixed to the wall. This cove base measured 6 inches. The ceiling to the dining room had dark brown splatters. The wall throughout this unit had dried splatters. The wall where the hand sanitizer was located had drips from the spout down the wall approximately 2 - 3 feet. The cabinetry/kitchenette lacked a finished surface. The entire dining room flooring was scuffed and marred. The wall adjacent to the calendar had an area that measured approximately 3 feet in width and lacked a painted surface. The doors to the dining room had multiple scratches too numerous to count		· Facility has contracted an outside contractor to do renovation to the Main Dining Room, Cottage and facility basement. · Housekeeping Supervisor or designee will monitor deep cleaning of rooms to ensure compliance **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** · Department heads will make daily rounds Monday through Friday, excluding Holidays and The manager on duty will monitor the Facility for environmental issues on the weekend, daily for 4 weeks and then weekly for 2 months and report findings to the Executive Director. · Maintenance Director will follow Preventative Maintenance program for repair and update. · To ensure compliance: The ED or designee is responsible for the completion of the Preventative Maintenance Program CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If	

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	that spanned the width of the door surface and spanned from the center section of the door to the bottom of the door. The resident room doors throughout the dementia unit had gouged out areas which spanned the entire width of the door surface. The bathroom door in Room 131 had a "punched" out section which measured approximately 1 inch. The wooden handrails throughout the unit were worn and lacked a finished surface. Upon entering the building on 03-06-11 at 8:40 a.m., all resident care areas and hallways had a build up of dirt, grit, grime and were unkept. During interview on 03-06-12 at 12:30 p.m., the Corporate Regional staff indicated, "I just took over this building in January [2012] and the entire building needed good housekeeping which included the use of soap and water." This Federal tag relates to complaint IN00104411. 3.1-19(f)		the threshold of 95% is not achieved an action plan will be developed to ensure compliance. **5. The facility alleges date of compliance on April 6, 2012**	

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review and interview, the facility failed to ensure an infection	F0441	It is the practice of the facility to establish and maintain an	04/06/2012

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	control program in which it ensured the documentation and surveillance of a contact transmission based pest, in that when a resident was observed with head lice/nits, the facility failed to ensure documentation related to their surveillance and potential for spread for 1 of 3 units, and 2 of 2 sampled resident's with the potential to affect 62 residents residing on 1 of 3 units. [Resident "C" and "D"]. Findings include: 1. The record for Resident "C" was reviewed on 03-06-12 at 10:30 a.m. Diagnoses included but were not limited to diabetes mellitus, anemia, anxiety. obsessive compulsive disorder, and mild intellectual disabilities. These diagnoses remained current at the time of the record review. Review of the Nurses Notes, dated 02-10-12 at 4:00 a.m., indicated the following: "CNA [certified nurses aide] noted prior to this entry during resident's scheduled shower the appearance of live lice on scalp during haircare. This nurse in to assess. Resident noted with 2 active et [and] visible lice with scant amount of cream around nits on hair shafts. Resident denies recent puritis [sic] of the		Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Both residents were treated for head lice per their physicians' orders. Subsequent scalp assessments per nursing were negative for lice or nits. Their room was deep cleaned. Clothing and linens were laundered. **2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected. All transmittable infestations and/or infections will be monitored and be under surveillance per facility policy. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · A policy specific to transmission based pests has been created. Staff education will be provided during in-services on March 27, 2012 by DNS · The SDC or designee will add all transmission based pests and/or infection to the Infection surveillance sheet	

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	scalp et of leaving the facility in [sic] LOA [leave of absence] in last several weeks. Resident also noted with multiple scabbed over et open abrased [sic] like lesions to scalp during assessment of scalp et hair. Above documented areas long standing from previous reaction to an ABT [antibiotic] therapy. MD [Medical Doctor] notified of above entry et of areas to scalp." The physician instructed the nurse to "apply mayonaise [sic] to hair to saturate. Wrap with cap for 12 hours. Rinse and pick out nits with comb. Clean - soak bedding, hats, clothing, combs with pediculocide for 1 hour." "02-11-12 at 3:00 a.m. - This writer assessed scalp et hair to ensure erradication [sic] of live lice et nits. No evidence of either." A physician order, dated 02-20-12 at 4:00 a.m. instructed the nurse "apply mayonaise [sic] to scalp et hair saturating then wrap hair et scalp with plastic wrap for 12 hours. After 12 hour duration rinse and pick out nits and lice present with lice and nit comb. Clean/soak bedding hats clothing et combs with pediculocide for 1 hour. Problem: active lice et nits." A subsequent nurses note dated 02-21-12		and to the facility map **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNS or designee will monitor Monday through Friday all new MD orders for residents to include those with transmission based pest diagnoses in the infection surveillance and mapping procedure. On the weekend +/or holidays, any indication of a transmission based pest diagnosis will be called to the DNS or designee. · The DNS or designee will perform audits of the infection surveillance and mapping procedure weekly x 4 weeks, then twice a month x 2 months, then monthly thereafter. Results will be reviewed at the monthly CQI meeting · The DNS or designee is responsible for the completion of the Infection Control CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. **5. The facility alleges date of compliance on April 6, 2012**	

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	at 1:00 a.m. indicated "Res. [resident] had shower with mayo [mayonnaise] tx. [treatment] to head for lice. Mayo still on head at beginning [sic] of shift. Rinsed and combed out. Nits seen on shaft. No live lice seen. Nits removed easily. Nothing visual on white towel after towel drying. Will need to continue to monitor for outbreak of nits." During interview on 03-06-12 at 9:30 a.m., Licensed Practical Nurse, employee #5, indicated there were no further signs of nits or lice with this resident. When interviewed if other residents were assessed or treated, the nurse indicated that resident "C's" room mate had been treated as a precaution with Nix [a pediculocide used for lice], and no other residents had been observed with nits or active lice. 2. The record for Resident "D" was reviewed on 03-06-12 at 12:00 p.m. Diagnoses included but were not limited to cerebral vascular accident, depression, hypertension, seizure disorder and cognitive impairment. These diagnoses remained current at the time of the record review. The record indicated the resident had a physician order, dated 02-10-12, for "Nix as directed - lice tx. preventive due to			

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	room mate having nits." Review of the Medication Administration Record for February 2012 indicated the resident received the prescribed treatment on 02-10-12. 3. Review of the facility infection control surveillance data lacked documentation of the resident treated for lice/nits on two occasions, or that the resident's room mate also received preventative treatment for lice/nits. 4. During interview on 03-07-12 at 11:50 a.m., the Staff Development Coordinator indicated "The other residents who were on that unit were checked. "[Name of physician #1] wanted all of her residents checked but [name of physician #2] said he didn't think it was necessary." The Staff Development Coordinator provided a resident treatment record which indicated the resident who was a resident for physician #1, was checked for lice/nits on 02-13-12. When further interviewed about the delay in assessing the residents for lice/nits the Staff Development Coordinator indicated she was "not sure, I was just told everyone was checked." 5. Review of the "CONDITIONS & INFECTIONS PRECAUTION RECOMMENDATIONS," on 03-07-12 at			

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	9:00 a.m., indicated the following: "Conditions/Infections: Head (pediculosis) - Type of Precautions "C" [contact], Duration "U" [until time specified in hours after initiation of effective therapy], Comments - Follow physician orders for shampoo treatment - use gowns & gloves during treatment." 6. Review of the facility policy on 03-07-12 at 12:30 p.m., titled "Infection Control and Prevention Program," [bold type and underscored] and dated 10-2011, indicated the following: "GOALS [bold type]: The goals of the infection control and prevention program are to: 1. Decrease the risk of infection to residents through investigation and surveillance. 2. Monitor and identify occurrence of infection and implement appropriate control measure to prevent outbreaks and cross-contamination. 3. Implementation of acceptable standard of practice to correct problems related to infection control and prevention practices. 4. Maintain records to improve infection control and prevention processes and outcomes." "TRANSMISSION BASED			

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	PRECAUTION GUIDELINES [bold type and underscored]" "POLICY [bold type]: The facility shall utilize the appropriate infection control precaution guidelines based on the identified concerns or issues." "PURPOSE [bold type]: To maintain and institute the appropriate precautions to prevent the spread of infection." "Contact Precautions [bold type]: refers to measures that are intended to prevent transmission of infectious agents either by direct or indirect contact with the resident or the resident's environment." 7. "INFECTION CONTROL AND PREVENTION PROGRAM [bold type and underscored]" "POLICY [bold type]: The facility shall establish an Infection Control and Prevention Program to: * maintain records of the facility's incidence and corrective actions." "PURPOSE [bold type]: To guide the activities of the Infection Control and Prevention Program to achieve the program's goals." "OVERVIEW [bold type]: The Infection			

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	Control and Prevention Program is comprehensive in that it addresses detection,prevention and control of infections for residents and personnel. The major activities of the program include: * surveillance." 8. INFECTION CONTROL AND PREVENTION NURSE/INFECTION PREVENTIONIST [bold type and underscored]" "POLICY [bold type]: The facility shall designate a nurse to oversee and maintain the infection control and prevention program and activities." "DUTIES AND RESPONSIBILITIES [bold type and underscored]: * Conduct surveillance activities."' This Federal tag relates to complaint IN00104548. 3.1-18(b)(1)			

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F0465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe, sanitary and comfortable environment in common areas for all the staff and visitors for both the main floor and basement of the facility observed. Findings include: On 03-06-12 at 9:10 a.m., with the Maintenance Supervisor in attendance, the following was observed: Basement: The staff lockers were observed in the area adjacent to the laundry area. One of two staff breakrooms was located in the basement of the facility. The break area had two small tables and six chairs. The staff area was shared with heavy cleaning equipment. With the Maintenance Supervisor in attendance, the equipment was identified as a large floor scrubber and scrubbing pads, a carpet machine, and a top scrubber. The area was filthy with an abundance of dirt and grime throughout. The "breakroom" area was damp. The flooring had an abundance and build up of a dark gray/gritty	F0465	It is the practice of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Staff lockers will be moved out of the hall away from the laundry room. · The basement break room use has been discontinued. · The common area in the basement has been cleaned, painted and floor repaired. · Wall repairs and floor tiles will be repaired by an outside contractor. · Central Supply room has been cleaned and organized. · The Maintenance room has been cleaned and organized. · Auguste's Cottage utility room floors have been cleaned. · The storage closet will be removed during the Cottage renovation. · The staff rest room sink will be reattached to the wall and commode will be fixed to prevent water from running continuously.	04/06/2012

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	substance. The wall adjacent to the staircase lacked plaster board and the wooden 1 inch ferring strips/boards had a thick black/green substance adhering to the board surface. Although the cinder blocks were visible, the plasterboard was missing and this area measured approximately 7 feet in height by 4 feet in width. The flooring adjacent to this wall lacked a tiled surface and had exposed concrete. Thirty four floor tiles were missing. The juncture of where the floor and wall joined had a black built up substance and continued up the wall surface approximately 12 inches. The "Stock/Supply Room" had boxes on the floor that were too numerous to count. The supplies included briefs, cups, and other resident and facility supplies. The area was in total disarray. During this observation, the Maintenance Supervisor indicated the basement area "had flooded and we have 6 sump pumps down here, one is in the elevator shaft." The Maintenance room was in disarray with tools and repair equipment, etc. strew throughout. Main Floor: The staff breakroom on the		**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · No residents were affected by this practice. · All areas will be cleaned and repaired by April 6, 2012 **3. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.** · Stair way and common area will be put on a daily cleaning schedule. · Auguste's Cottage utility rooms will be cleaned on the hall cleaning schedule. · An outside contractor has been secured to do the painting and repair to the stair well and the floor. · Maintenance Director will make daily rounds and report findings to the Executive Director. · Maintenance Director will follow Preventative Maintenance program for repair and update. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.**	

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	first floor was shared with cleaning equipment/vacuum cleaners. Auguste's Cottage: The flooring to the "clean utility room" as well as the "soiled utility room" were stained with black/brown spots. The flooring was gritty while walking on it. The storage closet on this unit had paper and plastic debris on the floor. There was a build up of a black substance in the corner which spanned out towards the center of the closet approximately 12 inches. The light in this closet did not illuminate. The common Bathroom on this Unit had a handwashing sink. The sink had fallen away from the wall and a 1/4 inch gap was evident. The sink lacked caulking. The commode in this bathroom continuously flushed. This Federal tag relates to Complaint IN00104411. 3.1-19(f)		· Maintenance Director will make daily rounds and report findings to the Executive Director. · Maintenance Director will follow Preventative Maintenance program for repair and update. · The ED or designee is responsible for the completion of the Environmental CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. The facility alleges date of compliance on April 6, 2012	

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F0493 SS=C	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility Based on observation and interview, the facility failed to ensure covered individuals were aware of their role and obligations in reporting reasonable suspicion of a crime, in that the facility Administrator failed to post signage related to the Elder Justice Act for 1 of 1 policy's reviewed. This deficient practice had the potential to affect 120 of 120 residents currently residing in the facility. Findings include: During interview on 03-02-12 at 12:00 p.m., the Administrator indicated the facility staff had received inservice education related to Abuse and the Elder Justice Act. When further interviewed for a review of specific policy and procedures which included reporting reasonable suspicion of a crime against a resident, the Administrator indicated the facility had complied with the regulation.	F0493	It is the practice of the facility to have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were found to have been affected by the deficient practice · The Elder Justice Act poster is now posted by the employee time clock and in the employee break room. 2. **How will you**	04/06/2012

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	155072	A. BUILDING 00 B. WING	03/07/2012

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	During observation on 03-02-12 at 11:35 a.m., with the Administrator in attendance, signage or any type of posted notice in an area used by covered individuals which included the requirement to report, who is required to report, the time frame required to report and the employee's right to file a complaint against a facility that retaliates against the employee for filing a complaint or report under the Elder Justice Act, was not available in the facility. During further interview on 03-02-12 at 11:40 a.m., the Administrator indicated the corporation had not sent laminated signage, and questioned if it was the responsibility of the facility to provide specific signage related to the Elder Justice Act and ensure covered individuals were aware of their role and obligations in reporting reasonable suspicion of a crime. When interviewed on 03-02-12 at 11:45 a.m., Licensed Practical Nurse, employee #14, indicated, "If you're asking about our abuse policy we've had that for a long time. I'm not sure of what you mean about 'Elder Justice Act.'" 3.1-13(s)		**identify other residents having the potential to be affected by these same deficient practices and what corrective action will be taken?** · All residents have the potential to be affected. Staff will be provided education related to the Elder Justice Act during in-services on March 27, 2012 by the Executive Director · The Elder Justice Act poster is now posted by the employee time clock and in the employee break room. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Elder Justice Act signage has been posted for facility staff, and education will be provided during in-service on March 27, 2012 by Executive Director **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · ED will monitor placement of the signage Monday through Friday, with the exception of	

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			holidays. · The weekend manager will monitor placement of the signage on the weekends. · The ED/designee is responsible for the completion of the Elder Justice Act CQI tool weekly times 4 weeks, bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **5. The facility alleges date of compliance on April 6, 2012**	

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F0514 SS=C	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure complete records in that when residents purchased items from a shopping service the facility staff failed to itemize the purchases on the resident's inventory sheet for 3 of 3 residents who participated in the shopping activity in a sample of 5 and 2 of 2 supplemental sampled residents. [Residents "A", "B", "D", "F", and "G"]. Findings include: 1. During interview on 03-06-12 at 8:55 a.m., a concerned family member for Resident "A" indicated the facility took [resident] to the shopping service in September 2011, and allowed the resident to purchase items in the amount of $171.13. The family member further indicated [resident] has dementia, and I	F0514	It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;accurately documented; readily accessible; and systematically organized. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Social Service staff or designee will assist the residents' POA in completing a new inventory sheet for the residents' personal possessions and after completion will place it in the residents' medical record **2. How will you identify other residents having the potential to be affected by these same deficient practice**	04/06/2012

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	have power of attorney, and they should have asked me first before they did that. When I checked [resident's name] closet there were no new clothing items there." A review of the "Merchandise Invoice, dated September 6, 2011, for the amount of $171.13 for "jewelry item [$5.99], ladies 6 pk. [pack] socks [$8.99], 2 pc. [piece] decorative trim capri [$31.99], 2 pc Print knit [$32.99], 2 pc. print sweat [$29.99], Supportive undergarment [$19.99]." This invoice was signed by the Activity Director as well as the resident. The resident's inventory sheet lacked documentation of the purchases. 2. The record for Resident "B" was reviewed on 03-07-12 at 10:35 a.m. The record indicated the resident had a diagnosis of dementia and was severely cognitively impaired with both short term and long term memory loss. Review of the resident's trust account ledger, dated 10-24-11, indicated "clothing $53.56." During interview on 03-07-12 at 8:25 a.m., the Activity Director indicated the activity staff notified the guardian about the purchase of the clothing after it was purchased by the resident. "[Guardian]		**and what corrective action will be taken?** · All residents have the potential to be affected. Residents' personal inventory sheets will be audited and updated as needed **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Residents' personal inventory sheets will be updated when new personal items are brought to the facility. The responsible parties for the residents will be requested to advise the nursing staff at the time new items are added to aid in the accuracy of the personal inventory sheets **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · During the monthly customer care calls to the residents' families/responsible parties, the facility customer care representative will request a list of any new items that have been brought to the facility since the	

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	said it was ok this time but not in the future, and that [guardian] would get all items for [name of resident]." The resident record lacked documentation on the inventory sheet of the items which were purchased 3. The record for Resident "D" was reviewed on 03-07-12 at 10:00 a.m. A diagnoses for the resident included persistent mental disorder. The resident was identified with severe cognitive impairment and resided on the secured dementia unit. Included in the resident record was information which identified a concerned family member as the "healthcare and financial" power of attorney. The facility provided a copy of items purchased on September 6, 2011 from the shopping service. The invoice indicated the resident purchased an embroidered knit sweater [$26.99], a 2 pc. print sweat. [$29.99], 2 pc. decorative trim capri [$28.99] and 2 pc print knit [$29.99] for a total of $155.10. This invoice was signed by the Activity Director. The resident inventory sheet lacked an accounting of the items purchased.		last update. If there were items brought in, the personal inventory sheet will be updated to reflect that information as needed · The customer care rep for each resident is responsible for completing the personal inventory CQI tool monthly times 3 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **5. The facility alleges date of compliance on April 6, 2012**	

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	4. The record for Resident "F" was reviewed on 03-07-12 at 10:25 a.m. The record indicated the resident had a diagnosis of Dementia with agitation and, depressive disorder. The record indicated the resident had an identified person as "general durable power of attorney. The record indicated the resident had "severe cognitive impairment." On 03-07-12 at 10:00 a.m., the Activity Director provided documentation/invoice, dated 09-06-11, in which the resident purchased items from the shopping service. This invoice was signed by the Activity Director. The items included ladies 6 pk socks [$8.99], ballerina slippers [$9.99], snuggies [$6.99], embroidered knit sweater [$26.99], 2 pc multiprint [$29.99], 2 pc. print knit [$29.99], and muu muu Dress [$21.99], for a total of $183.94. A "comment" at the bottom of the invoice indicated "took all." Review of the resident record inventory sheet lacked documentation of items purchased from the shopping service. 5. The record for Resident "G" was reviewed on 03-07-12 at 10:15 a.m. The			

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	record indicated the resident had a diagnosis of Alzheimer's disease and had severe cognitive impairment. In addition, the record indicated the resident had a concerned family member as the "healthcare and financial" power of attorney. On 03-07-12 at 10:15 a.m., the Activity Director provided an invoice, dated 09-06-11, for the shopping service. This invoice was signed by the Activity Director. The invoice indicated the purchase of "ladies 6 pk. socks [$8.99], 2 pc multiprint [$29.99], 2 pc. jewel two tone [$29.99]. and cotton gown [$14.99]." The total purchase was documented at $89.84. The "comment" section at the bottom of the Invoice indicated "took all." Review of the inventory sheet lacked documentation of the items purchased. During interview on 03-07-12 at 8:25 a.m., the Activity Director indicated "We [activity staff] don't add the items to the inventory sheet. For the residents on the Alzheimer's Unit their staff would have to bring them over to the shopping and then add to the inventory sheet." Interview on 03-07-12 at 9:40 a.m., Licensed Practical Nurse, employee #13, indicated "We don't add anything to the			

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	inventory sheet when they [in reference to the residents] go over there to shop. If that's something we're supposed to do, we'll do it." This Federal tag relates to Complaint IN00103352. 3.1-50(a)(1)			

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F0516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on observation and interview, the facility failed to safeguard records from possible destruction and unauthorized use in 1 of 1 medical records storage rooms observed affecting records stored in 43 cardboard boxes, 3 plastic bins and 9 binders. Findings include: Observation on 03-06-12 at 9:10 a.m., the Medical Record Storage room was observed in the facility basement. With the Maintenance Supervisor in attendance, the door to the medical records storage room was unlocked. During this observation, there were 8 ceiling panels which measured 3 feet in length by 1 1/2 feet in width, with brown stains which had spanned each panel.	F0516	It is the practice of the facility to not release information that is resident-identifiable to the public.It is the practice of the facility to release only information that is resident-identifible to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.It is the practice of the facility to safeguard clinical record information against loss, destruction or unauthorized use. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · All medical records in cardboard boxes were immediately removed from the basement storage area and	04/06/2012

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	There were 2 ceiling panels were missing. During this observation the Maintenance Supervisor indicated the stained areas were caused from condensation from the pipes within the structure of the ceiling panels. Located in this room were 43 cardboard boxes with lettering which indicated "resident records, rhc [respirations have ceased] and labs [laboratory] results." This storage room also contained 3 plastic containers and 9 binders also identified as "resident records." Review of the facility policy on 03-07-12 at 9:00 a.m., and titled "Retention of Discharge Records," [underscored], undated, indicated the following: "PURPOSE [bold type]: To retain discharge records in compliance with federal and state retention requirements, to store discharge records in an organized manner for ease of retrieval by appropriate individuals and agencies and to protect records from loss, destruction and unauthorized use." "STEPS [bold type]: 1.) When the resident's record has been completed and pertinent resident information has been entered in the Resident Index, file the		placed in approved storage containers and are being stored in an approved off-site storage facility **2. How will you identify other residents having the potential to be affected by these same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected. Medical records that are kept in the facility are stored in metal file cabinets in a secured area **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Medical records will be stored in metal filing cabinets in a secured area in the facility, and medical records stored off-site are in approved storage facility **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The ED will monitor the medical records storage areas in the facility to ensure proper	

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	record alphabetically in a metal file cabinet by the year discharged." The Director of Nurses provided an additional medical record policy on 03-07-12 at 12:50 p.m. which indicated, "RETENTION AND STORAGE - All clinical records, paper and computer based, shall be stored in a manner that safeguards clinical record information from loss, destruction and un authorized use." 3.1-50(d)		storage procedures are being followed by visually observing the areas once a week. Any deficiencies noted will be immediately corrected 5. **The facility alleges date of compliance on April 6, 2012**	

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F9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS (r) The hot water temperature for all bathing and handwashing facilities shall be controlled by automatic control valves. The water temperature at the point of use must be maintained between: one hundred (100) degrees Fahrenheit; and one hundred twenty (120) degrees Fahrenheit. This State rule was not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate hot water temperatures in that, the handwashing sink located in the kitchen failed to reach an adequate hot water temperature for handwashing for 1 of 1 handwashing sinks observed. Findings include: During observation on 03-06-12 at 9:30 a.m., the hot water to the handwashing sink in the kitchen appeared inoperable. The hot water was allowed to run for 10	F9999	It is the practice of the facility to meet Environment and physical standards. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The mixing valve for the hand washing sink in the kitchen was adjusted immediately to provide water with in the acceptable temperature range. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** · No residents were affected by this practice. · The mixing valve for the hand washing sink in the kitchen was adjusted immediately to provide water with in the acceptable temperature range. **3. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.** · The Maintenance Director or designee will perform daily water temperature checks.	04/06/2012

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	minutes. The Maintenance Supervisor, using the facility thermometer verified the hot water temperature was only 86 degrees. During interview on 03-06-12 at 9:40 a.m., the Dietary Supervisor indicated the hot water to the handwashing sink got "lukewarm at best. It's been like that for quite awhile." The Maintenance Supervisor indicated a "mixing valve" needed to be used on the sink, "because otherwise it would get too hot. This is the first I've heard about it." 3.1-19(r)		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** · Maintenance Director or designee will follow Preventative Maintenance program for water temperature monitoring. · To ensure compliance: The Maintenance Director or designee is responsible for the completion of the water temperature CQI tool daily. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance **5. The facility alleges date of compliance on April 6, 2012**	